CHAPTER III

DEFINING THE PROGRAMS FOR INCLUSION IN AN INDEPENDENT AGENCY

I. INTRODUCTION

In considering the programs to recommend for inclusion in an independent social security agency, the Panel began its deliberations with the assumption that OASDI, which the American public generally thinks of as "social security," should define the agency's basic mission. It then considered whether the new independent agency should continue to administer all the programs the present SSA does and, later, considered whether responsibility should be added for other programs not now administered by SSA, but which are programmatically or administratively related. The recommendations took account of the effect removing SSA from DHHS would have on that Department and its other programs. The Panel structured the removal of SSA so that minimum hindrance would occur to effective operation of the Department's remaining programs.

To assure a coherent operational mission, a newly independent social security agency should be responsible for administering the Old Age, Survivors, and Disability Insurance and the Supplemental Security Income programs. Other programs now administered by the Social Security Administration should remain in the Department of Health and Human Services. No program (including Medicare) currently administered by another agency should be brought into the social security agency.

These recommendations rest on the conclusion that making the new agency responsible solely for OASDI and SSI will maximize its chances of developing a coherent management philosophy and operating efficiently and effectively. By themselves OASDI and SSI represent very large and complex management and operational challenges. These programs share complementary objectives and a clientele with many common characteristics and needs. An agency responsible only for OASDI and SSI, with its more sharply focussed set of program responsibilities, offers the best chance to achieve managerial and operational excellence.

II. SUPPLEMENTAL SECURITY INCOME PROGRAM

The social security agency should continue to administer the Supplemental Security Income program. While there are programmatic differences between the OASDI and the SSI programs (particularly in criteria for eligibility and benefits and in sources of financing), program objectives and administration are closely related. Individuals establish entitlement rights to social insurance benefits by working in covered employment or self-employment for a specified period of time. Eligibility for SSI, on the other hand, depends on a showing that the applicant is poor, making it different in principle from social insurance, for which work histories and earnings records qualify applicants irrespective of need. SSI is funded out of general revenues, whereas social security is funded by an earmarked payroll tax on earnings. Historically, administration of means-tested programs was a State responsibility separate from federally administered insurance programs. Not until 1974, when the Congress set a Federal benefit floor and established other uniform Federal standards for aiding the needy who are aged, blind or

disabled (thus replacing categorical grants-in-aid to the States with a direct Federal program), did consolidated administration occur.

SSA undertook administration of the SSI program with serious reservations because of the likelihood that adding a means-tested program to one that provided benefits by right could confuse the public and overwork and demoralize the staff. It is now widely accepted that problems associated with the implementation of SSI in the mid-1970s were partly responsible for the decline in SSA's sense of mission and its operational efficiency and effectiveness.

The administration of SSI is now well integrated into SSA's operations, and there has been a great investment in achieving public and employee acceptance. Despite the differences in funding and philosophy that underlie the two programs, their purposes are complementary and there is substantial overlap of clienteles. (Some 50 percent of SSI recipients also receive social security.) As the minimum social security benefit has declined in importance as a floor of income support, the SSI program has become the primary means of ensuring a minimum level-of income to the elderly and disabled.

Removal of SSI from the social security agency would be highly disruptive to the program and would require setting up a new administrative mechanism. SSI is a uniform, national program--federally administered and financed. Many factors governing eligibility determinations made for OASDI are applicable to SSI, so coordination (especially of disability determinations) must be assured. If eligibility determinations, initial benefit calculations, and beneficiary monitoring and assistance were not conducted by social security offices, they would have to be done elsewhere,

most likely in other Federal facilities, which would thus lead to confusion for beneficiaries and to duplicative and wasteful efforts.

III. MEDICARE

Medicare and Medicaid should not be moved to the new social security agency, but should remain in the Health Care Financing Administration, an agency of DHHS. Several witnesses before the Panel recommended that Medicare (and perhaps Medicaid) be part of the new social security agency. (Medicare was in SSA prior to 1977.) However, other witnesses argued strongly this would be a mistake, from the point of view of both health policy and social security management. Arguments for and against placing these large Federal health care financing programs in the independent social security agency were carefully considered as the Panel received extensive testimony from persons with special expertise in the administration of health care financing. On balance, the Panel concludes that: (1) Medicare and Medicaid should remain under common administration, and (2) to place them in the social security agency would be detrimental to the sound future development not only of this agency, but of DHHS--as well as to both programs.

Major arguments advanced by those favoring an administrative reunion of social security and Medicare were:

0 Program Similarities

Medicare began as an adjunct to the social insurance programs, and most recipients consider Medicare to be an integral part of their social security entitlement. Like OASDI, Medicare is paid for largely by the payroll tax. Since these programs deal with

. basically the same client groups and rest on the same financial and

philosophical foundation, which presumes that payment of payroll taxes provides insurance against loss of income and the costs of illness for those who retire or become disabled, they should be administered by the same agency.

o Beneficiary Services

Several witnesses testified that service to Medicare beneficiaries has suffered since the program was separated from SSA. Witnesses asserted that beneficiaries have come to expect assistance and advice from SSA's district office personnel and that service for Medicare beneficiaries has gradually deteriorated. SSA field staffing allotments do not adequately take this service load into account and do not generally provide for training adequate to assist individuals with technical Medicare eligibility and coverage questions, especially those having to do with payments for physician services.

o Administrative Linkages

SSA currently-performs certain operational functions for the Health Care Financing Administration (HCFA) on a reimbursable basis. These consist mainly of establishing and maintaining Medicare eligibility at the social security field offices and providing certain data processing services on SSA computers, fairly routine operations that are largely by-products of SSA's own eligibility and computer-support activities. Advocates of reuniting OASDI and Medicare argue that these administrative operations would be facilitated by co-location in SSA and could suffer if the organizational distance between the two were increased.

While there is merit in these arguments, arguments against placing Medicare back in the social security agency are more persuasive.

The Panel concluded that rejoining OASDI and Medicare would be extraordinarily distracting and disruptive to the operations and policy development of the new social security agency. Furthermore, the organizational disruption that would accompany the transfer of HCFA's programs would damage that agency's program and policy development at a time when it needs to concentrate on improving both policy formulation and management in its own right.

The present administrative linkages between HCFA and SSA should be the subject of continued formal interagency agreements. Establishing workable relations between the social security agency and the Medicare agency will not be substantially more difficult if Medicare remains in DHHS while SSA is removed. This is not to say that the Panel is unconcerned about the need to improve the quality of field service to Medicare recipients. The Panel believes its recommendations will properly address the overall question of establishing and providing budgetary support for the proper level of public service to all beneficiaries, including service to Medicare recipients.

Placing Medicare in the social security agency would raise the question of the proper organizational placement of Medicaid. The Panel believes it is crucial for these two large health care financing programs to be administered by the same agency. In the 7 years since HCFA was established, progress has been made in policy and programmatic coordination of Medicare and Medicaid as health financing mechanisms that deal with common provider problems. Opportunity for further progress would be enhanced by keeping them together, and transfer of both to SSA would complicate that agency's mandates.

However, the principal reason for recommending that Medicare not be moved to the social security agency is that such a move would make the coordinated development of national health policy more difficult. Control of rapidly rising health care costs is certain to remain a major domestic policy issue for the foreseeable future. Medicare and Medicaid now pay almost one-third of total health care costs in the United States, and changes in them influence the entire health care system. Development of Federal health financing policy must be coordinated closely with policy development concerning the quality and availability of health care and the prevention of disease. These interrelated policy functions are more likely to be well coordinated if the major health financing programs remain in the same Department with the Federal health programs administered by such agencies of the Public Health Service as Centers for Disease Control, Food and Drug Administration, and National Institutes of Health. Moreover, from an organizational point of view, removing HCFA could so diminish DHHS's programs and mission as to jeopardize its departmental status.

If health care financing policy and programs were a responsibility of the social security agency, they would be an enormous drain on the social security agency Administrator's time and attention. HCFA program operations involve at least two substantial and disparate administrative processes, currently unrelated to SSA. For Medicare, the payment agencies are insurance companies and other contractors that serve as intermediaries. For Medicaid, the administration of the program is in State hands, and service to beneficiaries often involves concurrent dealings with contractors as well as with State welfare departments. Responsibilities for such added functions would drastically alter the internal structure of SSA and bifurcate the policy

apparatus. The Panel believes that the head of the social security agency should concentrate on improving the operational efficiency and effectiveness of the social security programs, capitalizing on the streamlined focus of the new agency. Similarly DHHS programs will constitute a coherent department if HCFA remains in DHHS.

IV. OTHER PROGRAMS NOW IN SSA

The Panel recommends taking certain programs now administered by the Social Security Administration out of the social security agency and placing them elsewhere within the Department of Health and Human Services. In particular, Aid to Families with Dependent Children, Child Support Enforcement, Low Income Home Energy Assistance, and Refugee Resettlement Assistance programs should not be part of the independent social security agency but should remain in the Department of Health and Human Services. While they all are income security programs, their target populations, eligibility concepts, and benefit delivery systems are vastly different from those of OASDI and SSI. All four are operated by State welfare and other State agencies, not by the Federal government, whose role consists largely of such regulatory and oversight activities as making certain that States conform to Federal statutory requirements. Separating these programs from the social security agency would not be disruptive either to the programs themselves or to the new agency. While administration of these programs now absorbs time and attention of top-level SSA managers, they are generally not integrated into SSA's main-line administrative operations, either in the central or field offices. Removing them from the social security agency would free its management from time and resource-consuming efforts on behalf of small,

unrelated programs. This narrowing of focus will facilitate operational and management improvements in the social security and SSI programs.

A further consideration in recommending that these programs remain in DHHS is that having them there, along with Title XX Grants for Social Services and Medicaid, would keep together in one department most of the major human resource programs that depend on Federal-State cooperation, enabling State welfare agencies to confine their contacts for these programs to one departmental setting. In addition, it could facilitate continued development of block grants and other policies affecting Federal-State income security and social service programs.

SSA currently administers the Black Lung program in conjunction with the Department of Labor (DOL). The Black Lung program consists of two distinct parts, B and C. Part B is a residual program which pays benefits to individuals who filed claims prior to 1974. The Part B program was designed to take advantage of SSA's existing disability program framework and processes and is still administered entirely by SSA. This workload primarily involves maintenance of service to a steadily decreasing beneficiary population. Part C, on the other hand, represents a legislative decision to have DOL administer the ongoing Black Lung program. Part C pays benefits to persons filing Black Lung claims after 1973. Thus DOL's Black Lung workload involves an increasing beneficiary population as well as maintenance of existing rolls. SSA's involvement in Part C is limited to the use of its field staff for taking initial claims. DOL reimburses SSA for these claims-taking services.

The procedures for dealing with SSA's diminishing administrative responsibility for Part B are currently well integrated into the organization, and continued operational responsibility for this part of the Black Lung

program is not a significant burden. Nonetheless, both parts of the Black Lung program should logically be administered by the same agency, and because the Panel strongly believes that the operational responsibilities of the social-security agency should be focussed sharply on the OASDI and SSI programs, it prefers that that agency be DOL. However, the Panel acknowledges that a decision to shift the Black Lung program entirely to DOL would require DOL to set up field offices for taking Black Lung claims, or contract with others to do so.